San Bernardino County Mental Health Plan

GRIEVANCE FORM

FORM TO BE COMPLETED BY ***CONSUMER*** AND FORWARDED TO THE ACCESS UNIT

700 East Gilbert Street San Bernardino, CA 92415-0920

Consumer Name: _____ Date: _____ Time: _____

Using Authorized Representative: Yes ☐ No ☐ If "Yes," Name: _____

Date of Birth: _____ Gender: _____ Preferred Language: _____

Home Address: _____

_____ Telephone: _____

Clinic or Provider: _____

Please Tell Us About Your Grievance: _____

_____

_____

_____

_____

_____

How Would You Like to See Things Resolved? _____

_____

_____

Consumer's Signature: _____ Date: _____

Authorization to Release Confidential Information

Once you have completed this grievance form, a staff member from the Access Unit will contact you to discuss your concerns. In order to help resolve your grievance, Access Unit staff will need to discuss your concerns with other individuals. These other individuals might include your service provider, your provider's supervisor, or administrators within the Department of Behavioral Health. In order to allow the Access Unit staff to discuss your grievance with these other individuals, we need to obtain your written permission to release information about your grievance.

I hereby authorize the staff of the Access Unit of the Department of Behavioral Health to release information contained in my grievance, as well as information obtained in the course of conversations with me about my grievance, to other members of the staff of the Department of Behavioral Health and/or contracted facilities of the Department such as Inpatient Hospitals/IMD facilities. The disclosure of this information is required in order to (1) assist in achieving a resolution of my grievance, and (2) help the Quality Improvement Program of the Department of Behavioral Health prevent similar problems from occurring in the future.

Date:_____ Signed:_____